STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000		F0000		

This visit was for Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on December 12, 2011.

Survey Dates: February 6, 7, 8, and 9, 2012

Facility Number: 012329
Provider Number: 155784
AIM number: 201002500

Survey Team:
Vicki Manuwal, RN-TC
Bobbie Costigan, RN
Susan Bruck, RN

Census bed type:
SNF: 27
SNF/NF: 47
Total: 74

Census payor type:
Medicare: 30
Medicaid: 28
Other: 16
Total: 74

Sample: 9

These deficiencies reflect state findings

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2. Quality review completed 2/15/12 Cathy Emswiller RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify a resident's physician of alteration in skin integrity requiring treatment for 1 of 4 residents (Resident # 17) reviewed with skin issues	F0157	**It is the practice of this facility to notify resident's physician and legal representative or an interested family member of accidents resulting in injury.**	02/29/2012

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	in a sample of 9. Findings include: The clinical record for Resident # 17 reviewed on 2/6/12 at 11:55 A.M. Resident # 17's diagnoses included, but were not limited to: hypertension, congestive heart failure, and atrial fibrillation. During initial tour on 2/6/12 at 10:10 A.M., LPN # 3 identified Resident # 17 as having a skin tear on the left elbow. Review of an "Accident/Incident Report" dated 1/21/12, indicated, "...during med (medication) pass found bandage on res (resident) L (left) arm c (with) Allyven (type of dressing) et (and) Kerlix (type of bandage) c ST (skin tear) 2.5 cm x .5 cm in size. Family notified. Stated they were aware, et witnessed. Happened during transfer c therapy....Physician Notified...1/21..." Review of a "Progress Notes" dated 1/20/12, indicated, "...Skin on left forearm scraped during a transfer from bed to wheelchair. Very accidental...." A second "Progress Notes" dated 1/20/12, indicated, "...Skin on her left forearm was scraped during a transfer from bed to		**CORRECTIVE ACTION:** Resident #17's physician was notified and treatment obtained for skin tear. **HOW OTHERS IDENTIFIED:** A 1 time review of in-house residents will be completed to ensure physician notification per policy with any accident/incident. **PREVENTATIVE MEASURES:** Communication form to be used to enusre that any accident/incident occuring in therapy is communicated appropriately to nursing staff. Re-education of nursing and therapy staff in regards to proper reporting with any accident/incident will be completed. **MONITORING:** DON/Designee and Therapy designee to meet Monday through Friday to review any communication forms. Results will be forwarded to facility Quality Assurance for further review and recommednations as deemed appropriate. Identified non-compliance will result in 1:1 re-education with progressive disciplinary actions per policy up to and incuding termination. This process will be indefinite. **COMPLETION DATE: 2/29/12**	

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	wheelchair. The therapists were very good with her...." Review of a "Witness Investigation Statement" dated 1/23/12, indicated, "...I noticed wound on Saturday 1/21/12. I notified nurse who said it happened in therapy. This therapist co-treated pt. (patient) on Friday and I was not aware of any injury. Pt was handled very carefully by 2 therapist in the presence (sic) of 2 family members...." A second "Witness Investigation Statement" dated 1/23/12, indicated, "...Date of Incident: 1/20/12...open area (L UE) (left upper extremity) noted in unknown origin...once up in chair; found draining on gown. Applied Foam dressing & Kling (dressing) to absorb drainage...No nurse available to report...." Review of a Physician Order, dated 1/25/12, indicated, "...Cleanse area to L elbow c N.S. (normal saline) pat dry, apply bacitracin, cover c telfa wrap c Kerlix q (every) day & prn (as needed) until healed..." During interview with LPN # 5 on 2/6/12 at 12:10 P.M., she indicated Resident # 17 received the skin tear with therapy during a transfer.			

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	LPN # 5 on 2/6/12 at 3:15 P.M., during interview indicated she and LPN # 6 discovered the skin tear already dressed and covered when they went in to check on the resident between 1st and 2nd shift. She further indicated therapy did not advise the nursing staff of the skin tear occurrence. During interview with the DON on 2/7/12 at 10:45 A.M., she indicated the therapist who dressed Resident # 17's skin tear is actually a wound specialist. She further indicated the therapist still should have reported the skin tear to the nurse. During interview with the Therapy Supervisor on 2/7/12 at 2:55 P.M., he indicated the therapist who dressed the skin tear told him there was no nurse available to report the skin tear to so she dressed it and went on with her day. He further indicated this was not how the situation should have been handled. The therapist failed to report the injury to nursing staff so they could contact the appropriate parties. He further indicated he inserviced the entire therapy staff regarding the proper way to communicate such situations to the nursing staff. The clinical record indicated Resident # 17's physician was not notified of the incident until 1/21/12 after LPN # 5			

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	discovered the skin tear. The clinical record further indicated the incident occurred on 1/20/12. 3.1-5(a)(1)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F0282	**It is the practice of this facility that the services provided or arranged by the facility are proivded by quailifed persons in accordance with each resident's written care plan. CORRECTIVE ACTION:** Res# 43's oxygen is being administered per physician's order. Res# 26 is receiving medication per physician's order. **HOW OTHER IDENTIFIED:** Audit of all resident's with orders for Oxygen to ensure that physician's order is being followed related to rate of flow. MAR's audited to ensure that documentation related that are not given have proper documentation an administered per parameters as applicable. **PREVENTATIVE MEASURES:** Directed In-service of all nursing staff on Policy and Procedure on Medication Adminsitration/Oxygen administration and following Physican Orders will be completed. DON/Designee will complete docuemtned monitoring for residents with orders for Oxygen to ensure that the rate of flow is per physician's order and MAR's will be monitored to ensure proper docuemnttion as well as following paramters for	02/29/2012

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	Based on observation, interview, and record review, the facility failed to ensure physician orders were followed for oxygen administration for 1 of 3 residents (Resident # 43) reviewed with oxygen, and failed to follow physician orders related to medication parameters for 1 of 9 residents reviewed for parameters (Resident #26) in a sample of 9. Findings include: 1. A clinical record review was completed for Resident #43 on 2/6/2012 at 3:25 p.m. Resident #43's diagnoses include, but were not limited to, COPD		physician ordered medications. **MONITORING:** DON and/or designee will monitor Oxygen delivery and MAR's daily for 2 weeks, then 3 times per week for 4 weeks, then weekly for 16 weeks, then monthly for 2 months.March 12, 2012 Addendum: All residents with oxygen will be monitored by the DON or designee and will cover all shifts. The MAR's will be monitored per the same schedule as the Oxygen. Results will be forwarded to facility Quality Assurance for further review and recomedations as deemed appropriate. Indentified non-compliance will result in 1:1 re-education with progressive disciplinary actions per policy up to and including termination.	

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	(Chronic Obstructive Pulmonary Disease), hypoxia, and HTN (hypertension). The MAR (Medication Administration Record) for February 2012 indicated, "...O2 1L/NC (1 liter of oxygen through the nasal canula) continuous while on Bipap (bilevel positive airway pressure)..." The nursing "Progress Notes" stated, "...1-17 8am...96% on 3L/NC...1-17 12N...O2 con't (continued) @ (at) 3L/NC...1-16 9pm...O2 is continuous @ 3L/NC...1-10-12 10pm...on O2 3L per NC..." The "SBAR Physician/NP/PA (SBAR-Situation, Background, Assessment, Recommendation; NP- nurse practitioner; PA- Physician Assistant) Communication and Progress Note" dated 1/11/12, indicated, "...increase O2 to 6L/mask...Hospitalization..." The "SBAR Physician/NP/PA Communication and Progress Note" dated 1/17/12, indicated, "...Resp. (respiratory) distress, 25 sec. (second) periods of apnea, somnolence. The problem/symptom started around 6 p.m. The problem/symptom has gotten worse (circled word)...Resp rate 24 Lung Sounds			

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	Diminished...O2 at 3 L/min (per minute)...To ER for evaluation...Reported to: Name Dr. (Name) MD Date 1/17/12 Time 7:30 pm..." The "SBAR Physician/NP/PA Communication and Progress Note" dated 2/6/12, indicated, "...O2 at 2 L/min..." The "Vital Signs- Individual Resident Flowsheet" indicated, "...1-16 8am...3L/NC...1-17 8am...3L/NC...1-17 7pm...R/A (room air)... The "Respiratory: Plan of Care" last updated on 1/23/12 indicated, "Need for oxygen therapy as ordered...Bipap, C-pap (continuous positive airway pressure) per physician order..." During an observation and interview on 2/6/12 beginning at 3:25 p.m. the DON (Director of Nursing) indicated that Resident #43's biox was 70% and he was being sent to the hospital. Resident #43 observed laying in the bed without oxygen, the oxygen running at 4L next to him and the nasal canula was observed under the foot of the bed. At 3:45 p.m. EMS arrive and inquire how many liters of oxygen Resident #43 was currently on. LPN#1 indicated, "...3 liters...," EMS place a nasal canula on Resident #43 running at 3L.			

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During an interview with the DON on 2/6/12 at 5:08 p.m. she indicated she put the O2 back on when she assessed him but was unsure of the setting.

During an interview on 2/6/12 at 5:35 p.m. LPN#1 indicated, "...he's on 2 liters because his CO2 (carbon dioxide) will go up..."

Surveyor: Manuwal, Vicki
2. The clinical record for Resident # 26 reviewed on 2/7/12 at 11:05 A.M., indicated diagnoses of, but not limited to: hypertension, congestive heart failure, and diabetes mellitus.

Review of a Physician Order dated 1/20/12, indicated, "Metoprolol Succ ER (extended release) 50 mg (milligrams)...give 1 tablet orally once a day...8:00 A.M....**hold for SBP (systolic blood pressure) < (less than) 110 or Pulse < 50...Assess BP (blood pressure)/Pulse q (every) 8 AM. Hold Metoprolol (blood pressure medication) (sic) & Diovan (blood pressure medication) for SBP < 110 or pulse < 50...Diovan 320 mg...give 1 tablet orally once a day...8:00 A.M...."

Review of the 1/20/12 through 1/31/12 MAR (Medication Administration Record) indicated the following blood

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	pressure results: 1/22/12 8 A.M.--Blood Pressure 111/77, Pulse 71. The MAR indicated the metoprolol and Diovan were both held. 1/26/12 8 A.M.--Blood Pressure 115/57, Pulse 77. The MAR indicated the metoprolol and Diovan were both held. 1/28/12 8 A.M.--Blood Pressure 111/63, Pulse 92. The MAR indicated the metoprolol and Diovan were both held. Review of a "Cardiovascular/Circulatory: Plan of Care" dated 1/20/12, indicated, "...HTN (hypertension)...Meds/Tx (treatment) as ordered...Vital signs per protocol..." The clinical record lacked documentation indicating why the above medication doses were held. During interview with LPN # 2, on 2/9/12 at 12:45 P.M., she indicated it is unclear to her why the medications would have been held for the above blood pressure readings. This Federal Tag was cited on 12/12/2011. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)			

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review, the facility failed to ensure the resident's oxygen was administered as ordered by the physician. This deficient practice affected 1 of 3 residents receiving oxygen in a sample of 9. (Resident #43) Findings include: 1. A clinical record review was completed for Resident #43 on 2/6/2012 at 3:25 p.m. Resident #43's diagnoses include, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), hypoxia, and HTN (hypertension). The MAR (Medication Administration Record) for February 2012 indicated, "...O2 1L/NC (1 liter of oxygen through the nasal canula) continuous while on Bipap (bilevel positive airway pressure)..."	F0328	**It is the practice of this facility that the services provided or arranged by the facility are proivded by quailifed persons in accordance with each resident's written care plan.** **CORRECTIVE ACTION:** Res# 43's oxygen is being administered per physician's order. Res# 26 is receiving medication per physician's order. **HOW OTHER IDENTIFIED:** Audit of all resident's with orders for Oxygen to ensure that physician's order is being followed related to rate of flow. MAR's audited to ensure that documentation related that are not given have proper documentation an administered per parameters as applicable. **PREVENTATIVE MEASURES:** Directed In-service of all nursing staff on Policy and Procedure on Medication Adminsitration/Oxygen administration and following Physican Orders will be completed. DON/Designee will complete docuemtned monitoring	02/29/2012

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	The nursing "Progress Notes" stated, "...1-17 8am...96% on 3L/NC...1-17 12N...O2 con't (continued) @ (at) 3L/NC...1-16 9pm...O2 is continuous @ 3L/NC...1-10-12 10pm...on O2 3L per NC..." The "SBAR Physician/NP/PA (SBAR-Situation, Background, Assessment, Recommendation; NP- nurse practitioner; PA- Physician Assistant) Communication and Progress Note" dated 1/11/12, indicated, "...increase O2 to 6L/mask...Hospitalization..." The "SBAR Physician/NP/PA Communication and Progress Note" dated 1/17/12, indicated, "...Resp. (respiratory) distress, 25 sec. (second) periods of apnea, somnolence. The problem/symptom started around 6 p.m. The problem/symptom has gotten worse (circled word)...Resp rate 24 Lung Sounds Diminished...O2 at 3 L/min (per minute)...To ER for evaluation...Reported to: Name Dr. (Name) MD Date 1/17/12 Time 7:30 pm..." The "SBAR Physician/NP/PA Communication and Progress Note" dated 2/6/12, indicated, "...O2 at 2 L/min..." The "Vital Signs- Individual Resident		for residents with orders for Oxygen to ensure that the rate of flow is per physician's order and MAR's will be monitored to ensure proper docuemnttion as well as following paramters for physician ordered medications. **MONITORING:** DON and/or designee will monitor Oxygen delivery and MAR's daily for 2 weeks, then 3 times per week for 4 weeks, then weekly for 16 weeks, then monthly for 2 months.March 12, 2012 Addendum: All residents with oxygen will be monitored by the DON or designee and will cover all shifts. The MAR's will be monitored per the same schedule as the Oxygen. Results will be forwarded to facility Quality Assurance for further review and recomedations as deemed appropriate. Indentified non-compliance will result in 1:1 re-education with progressive disciplinary actions per policy up to and including termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	02/09/2012

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	Flowsheet" indicated, "...1-16 8am...3L/NC...1-17 8am...3L/NC...1-17 7pm...R/A (room air)... The "Respiratory: Plan of Care" last updated on 1/23/12 indicated, "Need for oxygen therapy as ordered...Bipap, C-pap (continuous positive airway pressure) per physician order..." During an observation and interview on 2/6/12 beginning at 3:25 p.m. the DON (Director of Nursing) indicated that Resident #43's biox was 70% and he was being sent to the hospital. Resident #43 observed laying in the bed without oxygen, the oxygen running at 4L next to him and the nasal canula was observed under the foot of the bed. At 3:45 p.m. EMS arrive and inquire how many liters of oxygen Resident #43 was currently on. LPN#1 indicated, "...3 liters...," EMS place a nasal canula on Resident #43 running at 3L. During an interview with the DON on 2/6/12 at 5:08 p.m. she indicated she put the O2 back on when she assessed him and but was unsure of the setting. During an interview on 2/6/12 at 5:35 p.m. LPN#1 indicated, "...he's on 2 liters because his CO2 (carbon dioxide) will go up..."			

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	Surveyor: Manuwal, Vicki 2. The clinical record for Resident # 26 reviewed on 2/7/12 at 11:05 A.M., indicated diagnoses of, but not limited to: hypertension, congestive heart failure, and diabetes mellitus. Review of a Physician Order dated 1/20/12, indicated, "Metoprolol Succ ER (extended release) 50 mg (milligrams)...give 1 tablet orally once a day...8:00 A.M....**hold for SBP (systolic blood pressure) < (less than) 110 or Pulse < 50...Assess BP (blood pressure)/Pulse q (every) 8 AM. Hold Metoprolol (blood pressure medication) (sic) & Diovan (blood pressure medication) for SBP < 110 or pulse < 50...Diovan 320 mg...give 1 tablet orally once a day...8:00 A.M...." Review of the 1/20/12 through 1/31/12 MAR (Medication Administration Record) indicated the following blood pressure results: 1/22/12 8 A.M.--Blood Pressure 111/77. The MAR indicated the metoprolol and Diovan were both held. 1/26/12 8 A.M.--Blood Pressure 115/57. The MAR indicated the metoprolol and Diovan were both held. 1/28/12 8 A.M.--Blood Pressure 111/63. The MAR indicated the metoprolol and			

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	Diovan were both held. Review of a "Cardiovascular/Circulatory: Plan of Care" dated 1/20/12, indicated, "...HTN (hypertension)...Meds/Tx (treatment) as ordered...Vital signs per protocol..." The clinical record lacked documentation indicating why the above medication doses were held. During interview with LPN # 2, on 2/9/12 at 12:45 P.M., she indicated it is unclear to her why the medications would have been held for the above blood pressure readings. 3.1-47(a)(6)			